

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/18/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTSVILLE HEALTH AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>287 BAKER STREET</b> <b>HUNTSVILLE, TN 37756</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  Investigation of complaints TN00052131 and TN00052166 along with a COVID-19 Focused Survey was conducted on November 17-18, 2020, at Huntsville Health and Rehabilitation. No deficiencies were cited in relations to the complaints or survey under Chapter 1200-08-6 Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE